Health Care Planning and Accountability Advisory Council

Monday, March 11, 2013 2:00 p.m.

Department of Administration, Conference Room "A"

Co-chairmen: Steven Costantino, Secretary, Executive Office of Health & Human Services; Christopher Koller, Commissioner, Office of the Health Insurance Commissioner

Attendees: Alyn Adrain, MD; Timothy Babineau, MD; Kenneth Belcher; Jodi Bourque, Esq.; Al Charbonneau; Michael Fine, MD; Patricia Flanagan, MD; Herbert Gray; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.; Ed Quinlan; Fox Wetle, Ph.D.

Regrets: Peter Andruszkiewicz; Douglas Bennett; Nicki Cicogna; Robert Hartman; Gloria Hincapie George Nee; Donna Policastro, RNP; Sandra Powell; Louis Rice, MD; Marie Ganim, Ph.D; and Jane Hayward

Staff in Attendance: Michael Dexter, Chief, Office of Health Systems Development, Department of Health; Kim Paull, Director of Analytics, Office of the Health Insurance Commissioner; Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services

Jennifer Wood, Esq. and Dan Meuse from the Office of the Lt. Governor

Introduction

The Council meeting was convened promptly at 2:00 p.m. by Health Insurance Commissioner, Christopher Koller. Mr. Koller explained all of the documents contained in Council members' packets.

The minutes from the February 27, 2013 Council meeting were approved as written, with no additions or corrections.

The Council began with consideration of the ***Inpatient Hospital Capacity Findings.*** The intent of the Co-chairman was to get consensus on wording of each finding (findings will include respective citations).

The following findings were split out to discuss separately: findings # 1, 2, 3, 4, 5, 7, 8.

Care New England submitted comments on the draft findings. Mr. Andruszkiewicz of Blue Cross/Blue Shield of Rhode Island was not able to attend the meeting, but also submitted comments. The remainder of the findings will be voted "en bloc."

***Finding* #1:** Vote: None opposed; Attorney Bourque and Mr. Quinlan abstained.

***Finding* #2:** Vote: Vote: None opposed; Attorney Bourque and Mr. Quinlan abstained.

***Finding* #3:** Vote: 9: YES; NO: Mr. Belcher and Mr. Keefe
Abstentions: Attorney Bourque, Mr. Quinlan, and Dr. Babineau

***Finding* #4:** Vote: None opposed; Attorney Bourque and Mr. Quinlan abstained.

There was a unanimous vote not to use the Blue Cross data as part of this finding.

***Finding*#5:** Vote: None opposed; Attorney Bourque and Mr. Quinlan abstained.

Finding #7: Vote: None opposed; Attorney Bourque and Mr. Quinlan abstained.

***Finding*#8:** Vote: None opposed; Attorney Bourque abstained.

Primary Care Findings:

***Finding*#1:** Vote: None opposed; Attorney Bourque abstained.

***Finding*#3:** Vote: None opposed; Attorney Bourque abstained.

***Finding*#2** (Primary care) and Finding#6 (Inpatient Hospital Capacity) were voted "en bloc" with Attorney Bourque and Mr. Quinlan abstaining.

The Co-chairman indicated that edits to the Council's draft report would be appreciated after it is distributed to the Council for its review. An April meeting will be scheduled to discuss the final Council report that will be delivered to the General Assembly.

The Co-chairman sought public comment but there was none.

With no further discussion, the meeting adjourned at 3:55 pm.

Notes prepared and respectfully submitted by:

Elizabeth Shelov

Elizabeth Shelov, MPH/MSSW
Chief, Family Health Systems
Executive Office of Health & Human Services
March 29, 2013

Summary of the Findings & Recommendations

RI Inpatient Capacity: Findings

1. In Rhode Island, falling inpatient utilization combined with steady-to-rising bed supply has led to declining occupancy rates and excess supply of beds.

2. When forecasting the demand for inpatient beds in the state, the Council's consultant considered the following factors relevant: population changes, evolving patterns of inpatient utilization, primary care infrastructure, and target occupancy rate. In addition, Council members noted the impact of the economy and population health status on demand.

3. Using a model that takes the factors from Finding 2 into consideration, the projected number of inpatient staffed hospital beds needed in 2017 ranges from a shortage of 64 over current levels to a surplus of 338, depending on the combination of assumptions. The most likely set of assumptions models an excess of approximately 200 staffed beds.

4. The estimates of current hospital inpatient export (RI residents seeking care out of state) and import (non RI residents seeking care in state) patterns are as follows.

    a. **Exports**: The number of Rhode Island residents discharged from Massachusetts and Connecticut hospitals represents 5.7% of all RI hospital admissions and grew by 248 discharges per year between 2010 and 2011. Since 1997, exports per year have increased by 26%.
    b. **Imports**: The number of discharges from RI hospitals for out of state residents is about 8% of all RI hospital discharges. While these imports have grown by 756 discharges per year since 1997 (8.3% increase), they have fallen by 646 discharges per year from their relative peak in 2008, or 5% annually between 2008 and 2011**.**
    c. **Net Migration:** Overall, more patients from other states come to Rhode Island for hospital care than Rhode Islanders go to other states for care. However, the gap is narrowing.

5. The savings associated with eliminating excess inpatient capacity range from about $12m when only incremental costs are considered to more than $100m when all hospital costs are eliminated.

6. This report makes no formal findings on ways to identify and address the types of excess inpatient capacity but does discuss potential options

7. For certain procedures, there are generally-accepted volume thresholds below which quality is likely to be compromised. For some procedures, some Rhode Island hospitals do not meet these thresholds.

8. Many Rhode Islanders are willing to travel for their hospital care. The extent to which they travel varies by community and service.

9. Inpatient services are only half of a hospital's operating revenue; the rest comes from outpatient services. Additional study is needed to understand the array of outpatient services that various hospitals provide, how hospital-based outpatient services relate to other outpatient services available

in the communities they serve, and past and future trends in these areas.

10. Primary care physician (PCP) supply is higher in Rhode Island than in many other states, with 80 PCPs per 100,000 residents, which is the 8th highest ratio in the nation. However, the optimal rate is unknown.

11. Research indicates that the workforce, architecture, and organization of primary care physicians can greatly influence the demand for other medical services, including inpatient hospital services.

12. In Rhode Island, the potential reduction in hospitalizations (and thus on bed need) from a more integrated primary care delivery system alone may range from 6.2% to 43.9% for a very mature, integrated delivery system